

pt. Health,
, & Welfare
S. Public
th Service

S. 300
ev. 1-1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

XC-18407449

SL 7409

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

46340

STATE FILE NUMBER

11231

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MISSOURI b. COUNTY <i>St. Louis</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN LEMAY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>35 VETS ADMIN HOSP</i>		Length of stay in lb <i>7 DAYS</i>	d. STREET ADDRESS (If outside, give location) <i>27 329 PLACID</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>FRANK J. SMITH</i>			4. DATE OF DEATH Month Day Year <i>11-21-57</i>		
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/1/84</i>		9. AGE (In years last birthday) <i>73</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED SOLDIER</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>SYRACUSE, NEW YORK</i>	
10c. FATHER'S NAME <i>JOSEPH SMITH</i>		13b. MOTHER'S MAIDEN NAME <i>JUSTINE CRAFT</i>		14. NAME OF HUSBAND OR WIFE <i>FLORENCE SMITH</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>YES WW I</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT Address <i>VAH. RECCRDS 915 N. GRAND ST. LOUIS, MO</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<i>420.1</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORKING <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>11/14/57</i> to <i>11/21/57</i> and last saw him <i>her</i> alive on <i>11/21/57</i> Death occurred at <i>2:35 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Joseph H. Furst M.D.</i> (Degree or title)			22b. ADDRESS <i>VAH. ST. LOUIS, MISSOURI</i>		22c. DATE SIGNED <i>11-21-57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>Nov. 25, 1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>National Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Jefferson Bks. Mo.</i>
24. FUNERAL DIRECTOR <i>C. Holmeister Mortuaries</i> ADDRESS <i>7814 S. Broadway</i>			25. DATE RECD. BY LOCAL REG. <i>NOV 23 57</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> <i>m 9/5</i>

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Louis C. Hoffmann*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broad*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.